

Joint Review Committee on Education in Radiologic Technology
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Chicago, IL 60606-3182
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www.jrcert.org

## APPLICATION FOR RECOGNITION OF A CLINICAL EDUCATION SETTING IN RADIOGRAPHY FORM 104R

Sponsoring Institution:		Program #
. CLINICAL EDUCATION	SETTING FOR WHICH JRCERT RECOGNITIO	ON IS SOUGHT:
Name		
Address		
City	State	Zip Code
CES #	(To be assigned by JRCERT)	

### This application must be completed for each clinical education setting.

■ Consistent with JRCERT Policy 11.400, Procedure 11.404D, the JRCERT considers a clinical education setting as all radiologic facilities under a single radiologic administration within the campus. A campus is defined as the buildings and grounds of a school, college, university, or hospital that are geographically contiguous and does NOT include any geographically dispersed campus of a sponsor. Separate recognition is required for each facility not meeting this definition.

#### **■** Enclose:

I.

- a. An affiliation agreement with Affiliation Agreement Criteria sheet (see page 8).
- b. Form 102R for each designated clinical instructor and all required attachments identified on the form.
- c. Documentation of **current** The Joint Commission (TJC) accreditation or equivalent for the clinical education setting for which recognition is sought. For non-hospital clinical education settings that are not accredited, documentation of compliance with state and/or federal radiation safety regulations may be used as equivalent.

**NOTE**: Clinical Capacity Calculation Guidelines, page 5, is used by the JRCERT to identify the student capacity of the clinical education setting. DO NOT complete page 5.

- An application for recognition is not guaranteed. Recognition may be denied, or the capacity authorized may be less than that requested by the program.
- Fee please see the current Fee Schedule at www.jrcert.org.

JRCERT Form 104R Revised: 3-2011 Page 1 of 8

#### II. INSTITUTIONAL/PROGRAM OFFICIALS:

The signatures of clinical education setting officials and the director constitute a request for JRCERT recognition of the facility as a clinical education setting for the requesting program.

A. Chief Executive Officer of Clinical Educat	ion Setting:	
Name (Print)	Degree/Credentials	Title
Signature		
B. Clinical Instructor(s):		
Complete JRCERT Form 102R, and provide registration or unrestricted state license for expage(s) as necessary.)  • A minimum of one clinical instructor  • One full-time equivalent clinical instructor competency achievement process.	each individual listed. Duplicate and must be identified for each clinical	d add additional Form(s) and/oreducation setting.
Name		Degree/Credentials

Provide documentation of baccalaureate or higher degrees. (Although not required for clinical instructors, the JRCERT database will reflect degrees only upon submission of appropriate documentation. If degree documentation is not received for a clinical instructor, it will be assumed that the program does not wish to have the degree noted.) Documentation of the appropriate degree attainment from an academic institution accredited by an agency recognized by the United States Departemt of Eduction (USDE) or the Council for Higher Education Accreditaition (CHEA)

JRCERT Form 104R Revised: 3-2011 Page 2 of 8

**III. CLINICAL CAPACITY** - the JRCERT will determine the clinical capacity for this facility based on documented availability of appropriate imaging equipment and qualified practitioners to assure student attainment of program learning outcomes.

A. <u>Physical Resources</u> - List each of the imaging rooms/equipment at the facility and indicate the type. Please <u>check</u> the <u>ONE description</u> that best identifies the imaging equipment. [Duplicate and add additional page(s) as necessary]

			C	
Room/Equipment Identification (#, name, or other identifier)	Rad.	R&F	Mobile	Surgery

JRCERT Form 104R Revised: 3-2011 Page 3 of 8

**B.** List the qualified practitioners (ARRT registration in radiography or equivalent) that are assigned to <u>a typical</u> <u>weekday</u> (Monday-Friday) who perform imaging procedures. Indicate the primary area of daily practice and include shift hours. [Duplicate and add additional page(s) if necessary.] The student to radiography clinical staff ratio must be 1:1.

	Rad.	R&F	Mobile	Surgery	Other (specify)	Shift I	Hours
Name of Radiographer	_ 🗆					: begin	- <u>:</u> end
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JRCERT Form 104R Revised: 3-2011 Page 4 of 8

# THIS PAGE WILL BE COMPLETED BY THE JRCERT.

The following serve as guidelines for determining the total clinical capacity for the clinical education setting.

Type of Room	Number of Rooms/Machines	Multiplier	 Subtotal
Radiography		1	
R&F Combination		1	
Mobile (1-4 Machines) = .5 student placement OR	=.5	N/A	
Mobile (5 or > Machines) = 1 student placement	= 1	N/A	
Surgery (1-4 Machines) = .5 student placement. OR	=.5	N/A	
Surgery (5 or > Machines) = 1 student placement.	= 1	N/A	
Other			
Recognized Program # CC	Total Physical 1 Based on information from		
Recognized Program # CC  Recognized Program # CC	Total Personnel Based on information fr		
C	Total Clinical Cap Based on lower of two a		

CC Available for Applicant Program \_\_\_\_\_

JRCERT Form 104R Revised: 3-2011 Page 5 of 8

#### V. SITE UTILIZATION

A. Program seeking recognition for use of this facility. In the chart below, beginning with "Shift A", indicate the requested number of 1st year students to be assigned and the beginning and ending time of each day's rotation. If students are assigned to a second start/end time, please indicate in the "Shift B" section. If all students are assigned to the same start and end times, skip the "Shift B" section. Repeat these steps for the 2nd year students.

Wednesday

**Thursday** 

**Friday** 

**Tuesday** 

Monday

l <sup>st</sup> Year - 'Shift A"	// C.C.	<u>.</u>	;	:		:	;	:	:	;	:	·:				
		aenis	begin	end	begin	end	begin	end	begin	end	begin	end				
l <sup>st</sup> Year - 'Shift B"		idents	begin	: end	: begin	: end	begin	: end	: begin	: end	: begin	: end				
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'Shift A''		dents	begin	: end	: <b>-</b> begin	: end	begin	: end	begin	end	begin	end				
2nd Year			:	- :	: -		: .	- :	: -		: -					
<b>'Shift B''</b>	# of Stu		begin	end end	begin	end	begin	end	begin	end	begin	end end				
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JRCERT Form 104R Revised: 3-2011 Page 6 of 8

Programs should use this section to document comments.	
RADIOLOGY DEPARTMENTAL ADMINISTRATOR	
I agree that the information provided on this form is correct.	
Name (Print)	Title
Signature	
PROGRAM DIRECTOR - PROGRAM SEEKING SITE RECOGNIT	ION
FROGRAM DIRECTOR - FROGRAM SEERING SITE RECOGNIT	ION
I agree that the information provided on this form is correct and that if recognition	gnition of this site is granted,
the program will abide by the usage of the site as proposed.	
Name (Print)	Title
Signature	
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PROGRAM DIRECTOR - PROGRAM HOLDING CURRI  To be completed ONLY if site is to be s	
Pages 6 & 7 must be completed by ALL programs with	
(including those sites identified as ina	<u>ctive).</u>
I agree that the information provided on this form is correct and that if rec	cognition of this site is granted,
the program will abide by the utilization of the site as proposed on page 6	
	Program #:
Name (Print)	
Signature	

JRCERT Form 104R Revised: 3-2011 Page 7 of 8

#### VI. AFFILIATION AGREEMENT CRITERIA:

Program # **Sponsoring Institution:** Clinical Education Setting Name: The affiliation agreement must identify the following three (3) criteria as outlined below. Please identify where they are located by highlighting, circling, or otherwise indicating the verbiage in the body of the agreement and identifying the page and paragraph number in the space provided below. RESPONSIBILITY FOR STUDENT SUPERVISION: Page and Paragraph Number ADEQUATE NOTICE OF TERMINATION OF THE AGREEMENT: Page and Paragraph Number The JRCERT considers three (3) months notice of termination or assurance that students currently enrolled and assigned to the facility will be able to complete their clinical assignment at the facility. RESPONSIBILITY FOR LIABILITY: Page and Paragraph Number

Attach a copy of this page to the front of the signed affiliation agreement submitted.

NOTE: An affiliation agreement is not required for clinical education settings owned by the sponsoring institution. In these instances; however, a memorandum of understanding is encouraged.

JRCERT Form 104R Revised: 3-2011 Page 8 of 8